RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 3, 2018

Barry Bruns
HomeLife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AS390078924
10713 South 12th Street AFC
Investigation #: **2019A0462005**

Dear Mr. Bruns:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS390078924
Investigation #:	2019A0462005
Complaint Receipt Date:	10/25/2018
Investigation Initiation Date:	10/29/2018
Report Due Date:	12/24/2018
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	10713 South 12th Street AFC
Facility Address:	10713 South 12th St Portage, MI 49087
Facility Telephone #:	(269) 372-4820
Original Issuance Date:	11/06/1997
License Status:	REGULAR
Effective Date:	08/11/2018
Expiration Date:	08/10/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 10/14/2018 a direct care worker failed to administer Resident A his 2:00 PM dose of Gabapentin. Following the medication error Resident A's 2:00 PM dose of Gabapentin went missing.	Yes
Additional Finding	Yes

III. METHODOLOGY

10/25/2018	Special Investigation Intake 2019A0462005
10/29/2018	Special Investigation Initiated – Email referral to Kalamazoo County ORR.
11/02/2018	Contact - Telephone interview with RRO Suzie Suchyta.
11/02/2018	Contact - Document Received via email from RRO Suzie Suchyta.
11/19/2018	Contact- Telephone interview with assistant home manager Lillann Kaye and DCW Shakira Bonds.
11/26/2018	Contact- Telephone interview with DCWs Christine Browski, Iggy Lopez and Dora Woodard.
11/29/2018	Exit conference with licensee designee Barry Bruns.

ALLEGATION:

On 10/14/2018 a direct care worker failed to administer Resident A his 2:00 PM dose of Gabapentin. Following the medication error Resident A's 2:00 PM dose of Gabapentin went missing.

INVESTIGATION:

On 10/26/2018 Kalamazoo County Adult Protective Services denied this complaint for investigation and forwarded it to the Bureau of Community and Health Systems (BCHS) through the BCHS' on-line complaint system. On 10/29 I referred this complaint to the Kalamazoo County Office of Recipient Rights.

On 11/01 I conducted a telephone interview with Recipient Rights Officer Suzie Suchyta who informed me that she was investigating this allegation. Per information gather during her investigation, Ms. Suchyta stated on Sunday 10/14 direct care worker (DCW) Shakira Bonds forgot to administer Resident A his 2:00 PM dose of three 300mg tablets of Gabapentin. Later that day DCW Christine Browski discovered the three Gabapentin tablets still in the bubble pack and reported the medication error to the facility's on-call manager. The facility's assistant home manager Lillann Kaye confirmed the medication error the next day, Monday 10/15. Per information gathered during her investigation, Ms. Suchyta stated that on Tuesday 10/16, Ms. Browski discovered the Gabapentin tablets were no longer in the bubble pack. Ms. Browski also discovered that Ms. Bond's initials, along with the date of "10/14", were handwritten on Resident A's bubble pack of Gabapentin, indicating that the medication was administered as prescribed at 2:00 PM on 10/14. According to Ms. Suchyta, Ms. Browski reported this to assistant home manager Ms. Kaye. During Ms. Suchyta's interview with Ms. Bonds, Ms. Bonds denied removing the tablets after making the error on 10/14 and falsifying documentation on Resident A's bubble pack of Gabapentin. Ms. Suchyta stated that according to Ms. Bonds, someone else either stole or disposed of the medication and then forged her initials on Resident A's Gabapentin bubble pack. Ms. Suchyta stated that two other DCWs worked during this time. However, Ms. Suchyta did not suspect any wrong doing on the behalf of these individuals. According to Ms. Suchyta, the medication Gabapentin could cause an individual to become "high" if enough of the medication was consumed. Ms. Suchyta stated that she believed either someone attempted to cover up the medication error by disposing of the Gabapentin tablets and then documenting the medication as given at 2:00 PM on 10/14, or someone stole the Gabapentin tablets and attempted to cover it up.

Via email exchange, Ms. Suchyta submitted a picture of Resident A's bubble pack for his 2:00 PM dose of Gabapentin. Upon observation, I established that the pharmacy packaged three 300mg tablets of Gabapentin together in each individual bubble pack punch. I compared the initials "SB", as well as the handwritten date of "10/14" to other documentation by Ms. Bond, as well as to other DCWs' documentation, on Resident A's Gabapentin bubble pack. Although similar, there was no way for me to determine with certainty who wrote "SB" and "10/14" next to the missing Gabapentin tablets on Resident A's Gabapentin bubble pack.

On 11/19 I conducted telephone interviews with assistant home manager Lillann Kaye and DCW Shakira Bonds. Ms. Kaye's statements were consistent with the statements Ms. Suchyta provided to me. Ms. Kaye stated that on 10/15 she confirmed that Ms. Bonds forgot to administer Resident A his 2:00 PM dose of Gabapentin on 10/14. Ms. Kaye stated she also observed the 10/14 Gabapentin tablets still in the bubble pack on 10/15. Ms. Kaye explained that when a dose of medication was not administered to a resident due to a resident refusal or a medication error, DCWs did not dispose of the medication. Rather, the medication was left in the medication bubble pack and used at the next medication pass. Ms. Kaye stated that this was one of the reasons why DCWs administering medications

were required to write their initials and the date a medication was administered on residents' medication bubble packs next to each individual medication punch, in addition to documenting the administration of medication on residents' individual medication administration records (MAR). Ms. Kaye stated that she compared the initials "SB", as well as the handwritten date of "10/14" on Resident A's Gabapentin bubble pack to Ms. Bond's hand writing. According to Ms. Kaye, although both were similar, she believed that someone forged Ms. Bonds' initials on Resident A's Gabapentin bubble pack after either stealing the Gabapentin tablets or disposing of them, to either cover up the theft or to get Ms. Bonds in trouble. Ms. Kaye stated that after making the medication error on Sunday 10/14, Ms. Bonds did not work again until Tuesday 10/16. Ms. Kaye stated that although she believed Ms. Bonds, she did not know who would have either stolen or disposed of the Gabapentin tablets and then falsified documentation on Resident A's Gabapentin bubble pack.

Ms. Bonds admitted to making a medication error on 10/14 when she failed to administer Resident A his 2:00 PM dose of Gabapentin. Ms. Bonds denied later stealing or disposing of the Gabapentin tablets and then falsifying documentation on Resident A's Gabapentin bubble pack.

On 11/26 I conducted telephone interviews with DCWs Iggy Lopez and Dora Woodard who both worked during this time. Both Ms. Lopez and Ms. Woodard stated that they were made aware of this incident when interviewed by Ms. Suchyta. Both Ms. Lopez and Ms. Woodard denied stealing or disposing of the Gabapentin tablets and falsifying documentation on Resident A's Gabapentin bubble pack.

I conducted a telephone interview with Ms. Browski. Ms. Browski's statements were consistent with the statements provided to me by Ms. Suchyta and Ms. Kaye. Ms. Browski stated that like Ms. Bonds, following her shift on 10/14, Ms. Browski did not work at the facility again until Tuesday 10/16. According to Ms. Browski, both her and Ms. Bonds worked first shift on 10/16 and Ms. Bonds administered medications to the residents on that day. Per the facility's best practice policy, Ms. Browski stated that she reviewed all residents' medication bubble packs following Ms. Bonds' medication pass. Ms. Browski stated that it was at this time she observed the "SB" and handwritten date of "10/14" next to the missing Gabapentin tablets on Resident A's Gabapentin bubble pack. Ms. Browski stated that she immediately reported this information to Ms. Kaye. Ms. Browski denied stealing or disposing of the Gabapentin tablets and falsifying documentation on Resident A's Gabapentin bubble pack. Ms. Browski stated that although she had no proof, she believed that while administering medications on 10/16 Ms. Bonds disposed of the extra Gabapentin tablets and falsified documentation on Resident A's Gabapentin bubble pack to cover up her medication error. Ms. Browski stated that Ms. Bonds had recently made another medication error and may have been afraid of possible disciplinary action.

According to Special Investigation Report #2018A0581053, dated 09/18/2018, the facility was in violation of AFC administration licensing rule 400.14312(2) when it was established that Ms. Bonds administered the medication Metoprolol to a resident

when the medication should have been held. According to the facility's approved corrective action plan submitted to the department by licensee designee Barry Bruns on 09/27/2018, Ms. Bonds received a written warning and was required to complete remedial medication training before administering medications to residents in the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions. **(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.**
ANALYSIS:	Based upon my investigation, which included interviews with RRO Suzie Suchyta, assistant home manager Lillann Kaye and DCWs Shakira Bonds, Iggy Lopez, Dora Woodard and Christine Browski, as well as a review of pertinent documentation related to the allegation, it has been established that on 10/14 Ms. Bonds made a medication error when she forgot to administer Resident A his 2:00 PM dose of Gabapentin. On 10/16 it was discovered that Resident A's 2:00 PM dose of Gabapentin for 10/14 was missing. The initials "SB" and the date "10/14" were handwritten next to the missing medication on Resident A's bubble pack of Gabapentin. Ms. Bonds denied stealing or disposing of the Gabapentin tablets and falsifying documentation on Resident A's Gabapentin bubble pack. Ms. Bonds alleged that "someone else" stole or disposed of the medication, forged her initials and wrote the date "10/14" next to the missing Gabapentin on Resident A's bubble pack. Ms. Lopez, Ms. Woodard and Ms. Browski, who worked at the facility during this time, all denied stealing or disposing of the Gabapentin tablets and then falsifying documentation on Resident A's Gabapentin bubble pack. Ms. Kaye stated that although she believed Ms. Bonds, she did not know who would have either stolen or disposed of the Gabapentin tablets and falsified documentation on Resident A's Gabapentin bubble pack. While it is unknown what happened to Resident A's 2:00 PM dose of Gabapentin for 10/14, it has been established that the facility did not take reasonable precautions to ensure that Resident A's Gabapentin was not used by another person other than Resident A.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [REFERENCE SIR #2018A0581053 dated 09/18/2018 and CAP dated 09/27/2018].**

ADDITIONAL FINDING:

INVESTIGSTION:

I reviewed a copy of Resident A's October 2018 MAR. According to documentation on the MAR Resident A was prescribed three 300mg Gabapentin tablets to be administered three times daily at 8:00 AM, 2:00 PM and 8:00 PM. Per DCWs' initials on Resident A's MAR, Resident A's was administered his Gabapentin as prescribed for the entire month of October, including at 2:00 PM on 10/14.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	DCW Shakira Bonds made a medication error when she forgot to administer Resident A his 2:00 PM dose of Gabapentin on 10/14. Per DCWs' initials on Resident A's MAR, Resident A's was administered his Gabapentin as prescribed for the entire month of October, including at 2:00 PM on 10/14. It has been established that documentation on Resident A's October MAR was not accurate.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/29 I conducted an exit conference with licensee designee Barry Bruns via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

11/29/2018

Michele Streeter — Date
Licensing Consultant

Approved By:

12/03/2018

Dawn N. Timm — Date
Area Manager